From Alma-Ata to Rio: health for all to all for equity

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The WHO South-East Asia Region was one of the crucibles for development of the primary health care (PHC) concept. The Bandung Conference on Rural Hygiene held in 1937 drew global attention, through the League of Nations Health Organization, to the health needs of the poor rural populations. The first primary health units were started in Ceylon (now Sri Lanka) and Mysore state of Southern India in 1929. The Government of India established Health Survey and Development Committee (Bhore Committee) in 1946, identified access to safe water, sanitation, housing and adequate nutrition as essential conditions for healthy living with a curative-preventive mix of services available irrespective of the ability to pay, and emphasized intersectoral actions. Subsequently, primary health centres developed in several countries to reach the rural and marginalized populations. In Bangladesh, India, Indonesia, Nepal, Pakistan, Sri Lanka and Thailand several community-based primary health care experiments by civil society organizations complemented the primary health care system development by the State. These advances made significant contribution to the development of primary health care (PHC) as an approach to health system strengthening.

In 1976, a symposium organized by the Indian Council of Medical Research, New Delhi concluded that primary health centres should include primary medical care, an efficient referral system, maternal and child health (MCH) services, environmental sanitation, safe water supply, health intelligence, control of communicable diseases, school health, family planning, health education, recording of births and deaths, and family folders. A symposium held in 1980 focused on the evaluation of alternative health-care experiments. It endorsed the development of a network of frontline health workers to link communities with PHC teams and highlighted innovations like health cooperatives, nutrition-linked programmes and the use of local and traditional health resources and human power.

The 1978 Alma-Ata declaration ushered in a new paradigm of health focused on PHC and health for all. It emphasized equity, appropriate technology, inter-sectoral development and community participation, and health as a right. However, the significance of these radical concepts was soon lost, as focus continued on communicable diseases and MCH problems, with a more orthodox approach of tracking mortality and morbidity trends resulting in single disease-oriented approaches. Subsequently noncommunicable diseases and occupational/environmental health problems emerged as new priorities. Broader determinants like lifestyle behaviours, individual and collective risks and other

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upstream factors were identified, leading to broadbased health promotion strategies in many regions including Asia.

Synergy as well as dissonance developed between the PHC-oriented policies and national disease control programmes in the 1980s. Some deviations also took place in the 1990s. Globally, the new economic policies led to declining health and social sector budgets, which affected the development of the PHC infrastructure. Increasing numbers of global public-private partnerships, with a selective biomedical disease control focus, contributed to the shift from comprehensive PHC to top-down techno-managerial approaches. Social justice and equity, links between health and development, intersectoral coordination, community participation in health decision-making and health as a universal human right, which were at the core of the Alma-Ata declaration, received less attention. Market approaches to health care prevailed with growing privatization and commercialization.

At the same time, a broader social analysis of the health situation and health system also evolved. The earliest descriptions came from India in the 1980s and from London, United Kingdom, in the early 1990s. The former reiterated that “health service development is a socio-cultural process, a political process, a technology and managerial process with an epidemiological and sociological perspective”. The latter emphasized that “the primary determinants of disease are mainly economic and social and medicine and politics cannot and should not be kept apart”.

From the late 1990s, as health disparities widened, an increasing convergence between socio-epidemiologists, public health practitioners, and social activists took place with a strong community voice. They were alarmed at the increasing inequity between and within countries. Innovative projects to monitor global and regional inequities evolved such as the Global Equity Gauge Alliance. A growing global campaign for health for all as a fundamental human right also began to emerge. In 2000, the first People’s Health Assembly in Savar, Bangladesh explored why the Health for All goal had not been reached. A People’s Charter for Health adopted in the Assembly stressed the principles of universal comprehensive PHC envisioned in the 1978 Alma-Ata declaration. It stressed that “now more than ever” an equitable, participatory and intersectoral approach to health and health care was needed. The Global Forum for Health Research in Geneva, Switzerland took this charter seriously and interacted closely with civil society researchers at its annual forum to discuss the issues of poverty and health and the emerging concept of social vaccines. Between 2002 and 2004 people’s movements around this charter actively advocated for putting social determinants of health on the global agenda. This led to significant initiatives that are now changing the paradigm of health policy and action.

The World Health Report (2008) endorsed equity, solidarity and social justice to drive the PHC movement. It made evidence-based arguments for PHC reforms to improve health equity, to make health systems more people centred, health authorities more reliable, and to promote and protect the health of communities. As part of the “the way forward” it emphasized the need for mobilizing the production of knowledge, commitment of the workforce, and participation of the people. The WHO Commission on Social Determinants of Health (2008) urged governments, policymakers and health activists to participate actively in the global effort to redress inequities in health between and within countries as an issue of social justice. It explored the deeper social determinants of health equity, gender, political empowerment,
social protection, healthy environment and employment, etc. The Second Global Health Watch Report offered an alternative analysis arguing for policy changes, more research, social accountability, market regulation and appropriate interventions to support PHC with an equity focus when markets fail.

Recently in October 2011, government representatives, supported by the largest-ever presence of global civil society, expressed their determination to achieve social and health equity through action on social determinants of health and well-being within a comprehensive intersectoral approach. The most significant part of the Rio Declaration was the reiteration that “health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an ‘all for equity and health of all’ global action”. While this may sound rhetorical, there were new elements of realism in the declaration including the commitment to “empowering the role of communities” and “strengthening civil society contribution to policy-making and to take action in advocacy, social mobilization and implementation on social determinants of health”. The Third Global Health Watch Report released at the Rio conference complemented this global realism by highlighting a set of achievable goals through a global “Right to Health” movement that would foster recognition of the right to health and health care at country level, formation of health rights monitoring bodies and accountability agents, and regional and global solidarity on health rights campaigns.

Today, the PHC challenges at community level in countries of the Region include agrarian distress like farmers’ suicides, childhood malnutrition, economic downturns affecting PHC systems, climate change, social conflicts and disasters affecting the broader context in which health systems have to be developed and sustained. These require study of factors such as poverty, inequity, exploitation, violence and marginalization. Recently this understanding was put into action to strengthen public health and epidemiology.

To conclude, the WHO South-East Asia Region has seen an emerging responsiveness, by governments and peoples’ health movements, for public policies that have begun to influence the public health systems in the Region. The Thai National Health Act and the Indian National Rural Health Mission are significant examples of civil society engagement and responsive government policies and partnerships. These exemplify new developments that are equity-oriented and social determinants-focused. What is now needed is a continued evolution of this new paradigm. Research on public health policy, health systems strengthening, and community action for health equity are required in the Region. A new socio-epidemiology paradigm must begin to reinvestigate health challenges in the Region, building on the emerging convergence between civil society advocacy, academic analysis and responsive public policy. The systems for health training, research and policy formulation should be geared up to meet the “Health for All and All for Equity Challenge”.

References


